

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-010042

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 50

STATE FILE NUMBER

VS 300  
Rev. 4/59

1 1007

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USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Scott</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Sikeston</u>		c. CITY OR TOWN <u>Matthews</u>	
Length of stay in 1b <u>9 1/2 hrs</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Mo. Delta Community</u>		d. STREET ADDRESS (If outside, give location) <u>Rt. # 2</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Christine</u>		4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>63</u>	
First Middle Last <u>Christine Payne</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-29-1940</u>
9. AGE (last birthday) <u>22</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>13</u>	
11. IF UNDER 24 HR. Hours <u>5</u> Min. <u>10</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (City and state or country) <u>GRENADA, MISS.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>MARK MCCASTER SR.</u>		13b. MOTHER'S MAIDEN NAME <u>BERTHA MOSS</u>	
14. NAME OF HUSBAND OR WIFE <u>ALVIN PAYNE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>[REDACTED]</u>	
17. INFORMANT <u>MARK MCCASTER JR., MATTHEWS, MO.</u>		Address <u>[REDACTED]</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary infarct</u> DUE TO (b) <u>eclampsia</u> DUE TO (c) <u>[REDACTED]</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>None. Prenatal course essentially normal.</u>			
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
20c. TIME OF INJURY Hour <u>[REDACTED]</u> a.m. <u>[REDACTED]</u> p.m. Month, Day, Year <u>[REDACTED]</u>		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION <u>Sikeston</u>	
20g. COUNTY <u>Mo.</u>		20h. STATE <u>Mo.</u>	
21. I attended the deceased from <u>November 1962</u> to <u>2-11-63</u> and last saw her alive on <u>2-11-63</u> Death occurred at <u>2:30 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>E. D. Urban</u>		22b. ADDRESS <u>Sikeston</u>	
(Degree or title) <u>M.D.</u>		22c. DATE SIGNED <u>2/12/63</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>2-17-1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET OF MEMORY</u>		23d. LOCATION (City, town, or county) <u>SIKESTON, MO.</u>	
24. FUNERAL DIRECTOR <u>ALVIN DOTSON, SIKESTON, MO.</u>		25. DATE RECD. BY LOCAL REG. <u>2-20-63</u>	
26. REGISTRAR'S SIGNATURE <u>Janetta Waldman R.D.</u>			

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Willie R. Davis*

Licensed Embalmer No. *5129*

P. O. Address *Charleston mo*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.  
If this body is not embalmed, fact should be so stated above.